Answers to Frequently Asked Questions about Diagnosis and Demographic Reporting

Q. Why do diagnoses need to be submitted with demographic data, and why must a principle diagnosis be denoted?

A. Diagnostic information and demographic information enables the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) to respond to requests from the public, the legislature, AHCCCS and others regarding diagnosis in various population sets. Designation of a principle diagnosis is necessary for ADHS/DBHS to apply for and receive various grants and funding streams which depend on presence of certain principle diagnoses in defined populations.

Q. Doesn't designation of a principle diagnosis work at cross-purposes to the need to recognize and address co-morbid disorders?

A Co-morbid diagnoses are recognized because a complete set of diagnoses must be submitted along with the diagnosis deemed the principle diagnosis.

Q. What is a principle diagnosis, and how is it determined?

A. The principle diagnosis is the diagnosis which is most likely to be the main focus of treatment. It is determined by the clinician assessing the patient and ascertaining diagnosis.

Q. How is principle diagnosis communicated to ADHS/DBHS?

A. There is a separate field for entering principle diagnosis. Also, the diagnosis entered as principle diagnosis must be the first diagnosis listed on either Axis I or Axis II (that is, I.1. or II.1.) in the complete set of diagnoses.

Q. Does the principle diagnosis need to match the service enrollment category?

A. The principle diagnosis does not need to match the service enrollment category.

However, at least one diagnostic code on Axis I or II needs to be consistent with the behavioral health category. For example, a diagnosis appearing on Axis I of 297.1 Delusional Disorder would be consistent with enrollment as General Mental Health (GMH) or Seriously Mentally Ill (SMI).

Answers to Frequently Asked Questions about Diagnosis Data and Reporting

Q. Does diagnosis submitted for billing/encounter claims need to match the service provided?

A. Yes. For example, if the patient is seen for substance counseling, there should be a substance disorder diagnosis included in the billing.

Q. When billing/submitting an encounter claim, how many diagnoses may be submitted?

A. Up to four or eight diagnoses, depending on the form utilized (forms are standardized at the Federal level.)

Q. When billing/submitting an encounter claim, must ICD-9 codes be used?

A. Yes.

Q. Must ICD-9 codes be used in the clinical record?

A. No. We encourage the use of DSM-IV diagnoses for the clinical record, rather than ICD-9, as the DSM-IV is the official diagnostic manual of the American Psychiatric Association, and the DSM-IV contains diagnostic criteria for all psychiatric diagnoses, thus strengthening the diagnostic process.

Q. Don't DSM-IV diagnostic codes differ from ICD-9 diagnostic codes?

A. Currently, for all but four types of psychiatric disorders found in the DSM-IV, the DSM-IV codes and the ICD-9 codes are identical. Those four DSM-IV disorders are Substance-Induced Sleep Disorders, Narcolepsy, Adverse Effects of Medication Not Otherwise Specified, and Age-Related Cognitive Decline (which has no ICD-9 equivalent.)

Q. Does it matter that the names of DSM-IV disorders are different from the names of ICD-9 disorders with identical codes?

A. No. Only the diagnostic codes are scrutinized during data validation. The DSM was formulated with compatibility with the ICD in mind. It doesn't matter, for example, that 314.9 in the DSM-IV is called Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified and in the ICD-9 is called Unspecified Hyperkinetic Syndrome of Childhood. It's the same disorder.

Q. The ICD-9 contains a number of diagnoses which are not found in the DSM-IV. May those be used for billing/submitting an encounter claim?

A. There are a number of ICD-9 diagnoses/codes not found in the DSM-IV. The ADHS/DBHS Covered Behavioral Health Services Guide indicates codes from the ICD-9 Manual in the range of 290.00 to 316.99 will be accepted for behavioral health billing. Caveat: If ICD-9 diagnoses such as 298.2 Reactive Confusion, 301.11 Chronic Hypomanic Personality Disorder, or 313.1 Misery and Unhappiness Disorder Specific to Childhood and Adolescence, for which no DSM-IV equivalent diagnoses exist, are utilized, it may be difficult to demonstrate that the diagnosis is accurate since the ICD-9 does not contain diagnostic criteria.

Q. What is the best way to make sure that the diagnostic code used for billing/submitting an encounter claim matches the service provided?

A. The best way is to write diagnostic codes accurate to all digits on the progress note, and then to make sure billing clerks and all subsequent clinicians utilize those diagnoses, until such time as the diagnoses are changed. We recommend utilizing DSM-IV diagnoses and codes, which currently will have the same diagnostic codes as the ICD-9, with the exception of Substance-Related Sleep Disorders, Narcolepsy, or Adverse Effects of Medication Not Otherwise Specified, which can be “cross-walked” to the ICD-9 if diagnosed.